

OFFICE OF VOCATIONAL REHABILITATION

Verification for Subminimum Wage Employees

Consumer Information

Name:					
Street Address:					
City:		State:		Zip Code:	
Birthday:					

High School

- Transition Service Under IDEA: Yes No
- Pre-Employment Transition Services: Yes No

Vocational Rehabilitation

Applied for Services Date:

Ineligible Date:

Eligible Date:

Successful Closure Date:

Unsuccessful Closure Date:

Does not want VR Services at this time

Description of Refusal/Reason for Refusal:

Career Counseling Provided Date:

Resources Provided (Attach copies if applicable):

Documentation Submitted to: _____

Date of Delivery:

Method of Delivery:

Hand Delivered

Fax

Mail

Email

Other: _____

Counselor Printed Name: _____	Office Location: _____
Phone Number: _____	
Counselor Signature: _____	Date: _____